

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0050846

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No.

147

Primary Registration District No.

1002

Registrar's No.

7014

FILED JAN 17 1964

## 1. PLACE OF DEATH

a. COUNTY

Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)

Kansas City

Length of stay in 1b

48 Yrs.

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION

St. Luke's Hospital

Inside Limits

Yes ☒ No ☐

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

Jackson

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS

Kansas City

(If outside, give location)

8100 Wornall Road

Reside on Farm

Yes ☐ No ☒

## 3. NAME OF DECEASED (Type or print)

First  
EMMA

Middle

Last  
NEIL

4. DATE OF DEATH

Month Day Year  
Dec. 23, 1963

## 5. SEX

Female

## 6. COLOR OR RACE

White

## 7. Married ☐ Never Married ☒

Widowed ☐ Divorced ☐

## 8. DATE OF BIRTH

10-10-1870

## 9. AGE (last birthday)

93

## IF UNDER 1 YEAR

Months Days

## IF UNDER 24 HR

Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired - School Teacher

## 10b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (City and state or country)

Grand Pass, Missouri

## 12. CITIZEN OF WHAT COUNTRY

U. S. A.

## 13a. FATHER'S NAME

Unknown

## 13b. MOTHER'S MAIDEN NAME

Unknown

## 14. NAME OF HUSBAND OR WIFE

none

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Randolph Neil

Kansas City, Mo.

## 18. CAUSE OF DEATH (Enter only one cause per line)

### PART I. DEATH WAS CAUSED BY:

#### IMMEDIATE CAUSE (a)

Fracture right Hip & complication

## INTERVAL BETWEEN ONSET AND DEATH

12-20-63

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

#### DUE TO (b)

Pulmonary fibrosis & Emphysema (Severe advanced)

many years

#### DUE TO (c)

### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

### PART III. If deceased was female was there a pregnancy in last 90 days

☐ Yes ☒ No ☐ Unknown

## 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

## 20a. ACCIDENT

## SUICIDE

## HOMICIDE

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

## 20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

## 20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

## 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 20f. CITY, TOWN, OR LOCATION

## COUNTY

## STATE

## 21. I attended the deceased from

June 1963

to Dec. 23, 1963

and last saw her alive on 12-23-63

## Death occurred at

approx 3 PM

on the date stated above, and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

(Degree or title)

Samuel C. Petrie M.D.

## 22b. ADDRESS

6100 Montway Mission, Kans

## 22c. DATE SIGNED

12-24-63

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## 23b. DATE

12-26-63

## 23c. NAME OF CEMETERY OR CREMATORY

Mt. Washington

## 23d. LOCATION (City, town, & county)

Kansas City, Mo.

## (State)

## 24. FUNERAL DIRECTOR

## ADDRESS

Freeman Mortuary

Kansas City, Mo.

## 25. DATE RECD. BY LOCAL REG.

12-26-63

## 26. REGISTRAR'S SIGNATURE

Bessie Smith

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

Samuel C. Petrie MEDICAL CERTIFICATION

VS 300  
Rev. 4/59  
1  
2 3938  
3 2  
4 1  
5 0  
6  
7 0  
8 2  
9 525Y  
10  
11  
12 66-0  
13

DR. PETRIE

6100 MARTWAY

1 P.M.

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*J. H. Freeman*

Licensed Embalmer No. 2939  
P. O. Address F. C. MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.